TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Regional Plastic Surgery Center

Respondent Name
Facility Insurance Corp

MFDR Tracking Number
M4-17-0712-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 14, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is no always possible for a surgeon or surgical office to predict the nature of the surgery that will be required. The surgery that is required on a given patient is predicated upon the operative findings at the time of the procedure. [Claimant] in fact had a documented digital nerve neuroma by pathology. The CPT codes that were billed are legitimate and meet CMS guidelines."

Amount in Dispute: $3,269.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charge are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 22, 2016	64702, 64776 –XS, 64787 -XS	$3,269.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out guidelines for medical bill submission.
3. 28 Texas Administrative Code §134.600 sets out the requirements of prior authorization.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication

- 197 – Precertification/authorization absent
- 240 – Preauthorization not obtained
- 350 – Bill has been identified as a request for reconsideration or appeal
- 914 – The place of service is not supported by the documentation
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of $3,269.00 for outpatient hospital services rendered on July 22, 2016.

   The insurance carrier denied disputed services with claim adjustment reason code 914 – "The place of service is not supported by the documentation" and 240 - "Preauthorization not obtained."

   Review of the submitted medical claim finds in Box 24(B) of Form 1500, "22" or Outpatient Hospital. Review of the National Provider Identifier in box 32(a) or 1962568725 found a Taxonomy code linked to "Ambulatory Surgical."

   28 Texas Administrative Code §133.20 (c) requires that,

   > A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills.

   Based on the place of service "Outpatient" does not match the type of facility linked to the NPI number, the denial of "the place of service is not supported by the documentation" is upheld.

   In regards to denial code 240 – "Preauthorization not obtained." 28 Texas Administrative Code §134.600 (p) states in pertinent part,

   > (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;

   The requestor states, "We had authorized a 64774 code as well as 64832 code." Insufficient evidence was found to support prior authorization of any surgical procedures by the insurance carrier. Based on requirement of Rule 134.600(p)(2) not being met, the carrier's denial is supported.

2. Therefore, the Division finds no additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 28, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.